Emergency Contraception: Client Informed Consent and Referral

Client's Name: _____ Phone #: _____

Address: _____City: _____ State: _____ Zip: _____

Date of Birth (Month / Day / Year): ____ /_____ /_____

☐ I have been given the EC Key Facts and Instructions for Use and have had access to information about EC:

Client's signature _____ Date _____

Pharmacist's signature _____ Date _____

☐ I understand that it may be useful to share this treatment information with my regular health care provider. Therefore, I request and authorize the release of this information to the following designated provider:

No ☐ (Do not share)

Yes ☐ (To share) Name of Designated Provider _____

Provider's Address _____

Client's signature _____ Date _____

FOR PHARMACIST USE ONLY:

Client provided with:

- ☐ Key Facts Sheet
- ☐ Informed Consent (Form B - this sheet)

EC Product

- ☐ Plan B™
- ☐ Other

Referral Made for?

- ☐ Contraception
- ☐ STI/HIV
- ☐ Pregnancy
- ☐ Primary Care
- ☐ Sexual Assault
- ☐ Child Abuse (Call DCF 1-800-649-5285)

Additional pharmacist notes/comments:

_____

_____

_____

_____

Date:____/____/____ Time: ____:____ AM/PM (Circle One)

Pharmacist's Signature: _____R.Ph./Pharm D

Pharmacist: 1) Keep original copy for your records. 2) Give a copy to the client. 3) If release is authorized, give a copy to the designated provider.